U.S. Department of Veterans Affairs

Office of the General Counsel
Washington DC 20420

In Reply Refer To: **00REG**

January 27, 2022

Subject: Regulatory Impact Analysis for RIN 2900-AQ72(P), Schedule for Rating Disabilities – Ears, Nose and Throat and Audiology; Schedule for Rating Disabilities – Respiratory System

I have reviewed this rulemaking package and determined the following.

1. VA has examined the economic, interagency, budgetary, legal, and policy implications of this regulatory action and, based on VA's estimates, the Office of Management and Budget has concluded that it is an economically significant rule under Executive Order 12866.

2. This regulatory action is also a major rule under the Congressional Review Act, because it is likely to result in an annual effect on the economy of $100 million or more.

3. This rulemaking will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act, 5 U.S.C. 601-612.

4. This rulemaking is not likely to result in the expenditure of $100 million or more by State, local, and tribal governments, in the aggregate, or by the private sector, under the Unfunded Mandates Reform Act of 1995, 2 U.S.C. 1532.

5. Attached please find the relevant regulatory impact analysis document dated January 27, 2022

6. Written comments to this RIA may be submitted through www.regulations.gov. Comments should indicate that they are submitted in response to "RIA for RIN 2900-AQ72– Schedule for Rating Disabilities–Ear, Nose, Throat, and Audiology Disabilities; Special Provisions Regarding Evaluation of Respiratory Conditions; Schedule for Rating Disabilities–Respiratory System."

Approved by:
Roy Johnson
Chief Economist
Office of Regulation Policy & Management (00REG)
Office of General Counsel

(Attachment)

Regulatory Impact Analysis for RIN 2900-AQ72(P)

Title of Regulation: Schedule for Rating Disabilities –Ears, Nose and Throat and Audiology; Schedule for Rating Disabilities – Respiratory System

Purpose: To determine the economic impact of this rulemaking.

Statement of Need: The current version of the VA Schedule for Rating Disabilities (VASRD) has not undergone a complete revision since 1945 and currently reflects outdated, inaccurate, or obsolete medical, scientific, and/or economic information. This rule is being proposed to update medical terminology, incorporate medical advances, and provide disability compensation using more objective evaluation criteria consistent with current medical practice.

Summary: The Department of Veterans Affairs (VA) proposes to revise sections of 38 CFR Parts 3 and 4 that address the ear, nose, throat (ENT), audiology, and respiratory systems. The purpose of these changes is to update medical terminology, incorporate medical advances that have occurred since the last review, and provide well-defined criteria in accordance with actual clinical practice. Specifically, the last major revision to the Respiratory body system was in 1996 and it was in 1999 for the Ears, Nose and Throat and Audiology body system. VA will also rename the body system currently designated for conditions related to hearing and the ear, to include the nose and throat. VA will also consolidate within the scope of otolaryngology several diagnostic codes (DCs) currently listed within the respiratory system.

Benefits: This rulemaking allows for more accurate and adequate disability evaluations, ensuring adequate compensation for disabled veterans. Additionally, updating to reflect current medical and scientific standards allows for more efficient claims processing by matching currently accepted medical practice and assessment. This supports the Secretary's goal of providing benefits in a timely manner, modernizing systems, and ensuring Veterans can make informed decisions about the benefits they seek by basing them on current and familiar medical standards and practices.

Estimated Impact: VA has determined that there are costs and transfer savings associated with this rulemaking. The total transfers savings is $15 billion from FY 2022-2026 and $57.1 billion over a 10-year period from FY 2022-2031. This is detailed in Table 1 below. The transfer savings are estimated to be $944 million in FY 2022, $15 billion for five years, and $57.1 billion over a 10-year period from FY 2022-2031. These are detailed in Table 2 below. Additionally, VA has determined there are estimated government costs to cover salary, benefits, rent, travel, supplies, equipment, and other services of $3.4 million in FY 2022 and $15.8 million from FY 2022-2026. 10-year costs from FY 2022-2031 are estimated to be $19.1 million. These are detailed in Table 5 below.

Table 1 Total Budgetary Impact:

Fiscal Year	Transfers ($000)	GOE Costs ($000)	Total Budgetary Impact ($000)
2022	($943,944)	$3,483	($940,461)
2023	($1,969,793)	$4,651	($1,965,142)
2024	($2,994,510)	$4,868	($2,989,642)
2025	($4,047,274)	$1,899	($4,045,375)
2026	($5,099,967)	$872	($5,099,095)
5-Year Total	**($15,055,488)**	**$15,773**	**($15,039,715)**
2027	($6,179,657)	$634	($6,179,023)
2028	($7,266,854)	$652	($7,266,202)
2029	($8,381,894)	$669	($8,381,225)
2030	($9,525,087)	$687	($9,524,400)
2031	($10,686,787)	$708	($10,686,079)
10-Year Total	**($57,095,767)**	**$19,123**	**($57,076,644)**

Table 2 Transfers:

Total: VASRD ENT/Respiratory					
	Veteran Compensation		**Contract Exams**	**VHA Expenditure**	**Total**
Fiscal Year	**Caseload**	**Transfer Savings ($000)**	**Transfers ($000)**	**Transfer Savings ($000)**	**Transfer Savings ($000)**
2022	175,537	($892,025)	$8,081	($60,000)	($943,944)
2023	344,901	($1,858,655)	$8,862	($120,000)	($1,969,793)
2024	506,847	($2,823,809)	$9,299	($180,000)	($2,994,510)
2025	657,805	($3,819,361)	$2,087	($230,000)	($4,047,274)
2026	801,071	($4,811,612)	$1,645	($290,000)	($5,099,967)
5-Year Total		**($14,205,462)**	**$29,974**	**($880,000)**	**($15,055,488)**
2027	940,189	($5,821,172)	$1,514	($360,000)	($6,179,657)
2028	1,075,240	($6,848,345)	$1,491	($420,000)	($7,266,854)
2029	1,206,324	($7,893,397)	$1,502	($490,000)	($8,381,894)
2030	1,333,536	($8,956,617)	$1,530	($570,000)	($9,525,087)
2031	1,456,976	($10,038,352)	$1,565	($650,000)	($10,686,787)
10-Year Total		**($53,763,343)**	**$37,577**	**($3,370,000)**	**($57,095,767)**

Paperwork Reduction Act: Although this proposed rule contains provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521), no new or proposed revised collections of information are associated with this proposed rule.

Alternative Policy Approaches:

1. ***Not updating the Respiratory or Ear, Nose, Throat and Audiology body systems.*** VA considered not updating the rating criteria for these body systems; however, VA's policy objectives are to: (1) update the medical terminology of certain audiology, ENT and respiratory disabilities; (2) add medical conditions not currently in the Rating Schedule; (3) refine evaluation criteria based on medical advances that have occurred since the last revision; and, (4) incorporate current understanding of functional changes associated with or resulting from a disease, injury, or disability. More specifically, VA recognized that there were certain conditions within these body systems that did not provide evaluations based on average impairment to earning capacity as mandated by 38 U.S.C. 1155. VA also recognized that having the general rating formulas for both respiratory and cardiovascular body systems share one same evaluation criterion (Metabolic Equivalents or METs) could aid VA examiners overcome the challenge of trying to separately assess the functional impact of respiratory conditions from cardiovascular conditions. Additionally, VA sought to expand the exceptions for requiring speech discrimination (now identified as "word recognition") scores for former service members whose first language is not English and/or who have cognitive difficulties due to traumatic brain injuries. VA cannot achieve these goals through non-regulatory action (e.g., procedural manual changes or retraining). Failing to incorporate these policy objectives would render disability evaluations for these conditions less-than-adequate, inaccurate, and, in some cases, in conflict with current medical and economic understanding of disability. Not only could this conflict result in inadequate assessment of disabilities, it could also result in reduced efficiency in claims processing and delivery of benefits, as VA could not rely on modern medical records (when available) to quickly assess impairment due to a disability involving the audiology, ENT and respiratory systems. Failing to maximize efficiency in claims processing and delivery of benefits could result in decreased participation by veterans in not only the disability compensation program, but also with VA services on the whole.

2. ***Evaluate obstructive sleep apnea based on other criteria.*** VA also considered using the Apnea Hypopnea Index (AHI) and the pulse transit time arousal index (PTT Ar/I) to evaluate the severity of obstructive sleep apnea (OSA). AHI is the average number of times an individual experiences either an apnea (lack of breathing for 10 seconds or more) or hypopnea (partial blockage of airway) per hour for every hour that the individual is asleep. See American Academy of Sleep Medicine. Obstructive sleep Apnea. Illinois: American Academy of Sleep Medicine 2008. Normal AHI is considered to be less than 5. OSA is considered mild when AHI is between 5-15, moderate when AHI is between 15-30, and considered severe when AHI is more than 30. *Id.* Additionally, PTT Ar/I is the frequency (number/hour) of a defined decrease in pulse transit time, which may serve as a marker for respiratory events and arousals in individuals with OSA. See Schwartz DJ. The pulse transit time

arousal index in obstructive sleep apnea before and after CPAP. Sleep Med. 2005 May;6(3):199-203. doi: 10.1016/j.sleep.2004.12.009. PMID: 15854849. Potentially, VA considered assigning evaluations based on the mild, moderate, and severe severity levels of OSA as defined by the AHI; however, VA determined that this alternative policy approach was not viable because while AHI assesses the severity of the condition during the individual's sleep, VA is statutorily required to assign evaluations based on average losses in earning capacity in civil occupations, which is an assessment of an individual's functioning in an occupation while awake. Additionally, two individuals with the same AHI may experience the severity of OSA differently. This is because apneas are counted as long as they last for at least 10 seconds, but one individual's apnea could average 12 seconds while another's average 50 seconds. See Asghari, A., & Mohammadi, F. (2013). Is Apnea-Hypopnea Index a proper measure for Obstructive Sleep Apnea severity? *Medical journal of the Islamic Republic of Iran*, *27*(3), 161–162. Therefore, VA determined that establishing criteria based on the effectiveness of treatment was the most appropriate method to consistently evaluate the waking hours occupational impairment due to OSA.

Assumptions and Methodology of the Analysis:

Compensation and Pension Transfers

There are 74 existing and eight proposed new diagnostic codes (DCs) for VASRD ENT, audiology, and respiratory systems. The table above reflects combined transfer savings of all DC updates..

- Three existing DC updates have a major budgetary impact (defined for purposes of this methodology as greater than $100 million over five years) and are described in full detail below.
- Twenty-three existing and two new DCs have a minor budgetary impact (defined for purposes of this methodology as less than $100 million over five years) and are described in less detail below.
- Forty-eight existing and six new DCs have no updates or minor updates with no transfer costs or savings and are excluded from this methodology.

Although Veterans may be impacted by changes to more than one DC, for purposes of this regulatory impact analysis, the caseload from each DC was considered a unique count. Additionally, in accordance with 38 U.S.C. 1155, Veterans with service-connected ratings under any of the revised diagnostic codes will not have their evaluation reduced based solely on the change to the rating schedule. Instead, a reduction would only be warranted if it's shown that the Veteran's disability has improved under the prior criteria. For purposes of this estimate, VA also assumes Veterans would not apply for compensation for additional disabilities based on this rulemaking. Although certain Veterans would be eligible for less compensation when applying for benefits in the future, VA does not believe Veterans are withholding information on having additional disabilities from their claims for compensation currently. In addition, VA's recent efforts to modernize its schedule for rating disabilities has focused on more objective rating criteria.

An additional assumption underlying this analysis is that Veterans will not respond to the publication of the proposal with a surge in attempts to establish service connection for the relevant disabilities prior to rule finalization. VA may refine this assumption before publishing the final rulemaking to account for the various possible behavioral changes on the part of Veterans, and requests comment that would facilitate such refinement.

DCs with Major Budgetary Impact

1. DC 6847 – Sleep apnea syndromes

Under the current rating schedule for DC 6847, Veterans are rated at the 0 percent, 30 percent, 50 percent, and 100 percent levels. Under this regulation, VA proposes to add a 10 percent level, eliminate the 30 percent rating level, and update the rating criteria at the 0, 50, and 100 percent levels. The basis for assignment of evaluation at all of these proposed levels will be the functional impairment caused by sleep apnea, not simply the method of treatment.

The revised rating schedule for sleep apnea would only be utilized for newly granted claims. Veterans with service-connected sleep apnea ratings prior to publication of this regulation would continue to be covered under the current rating schedule unless they apply for an increased rating.

Based on the changes to the rating criteria, Compensation Service assumes Veterans rated 0 percent and 100 percent under the current rating schedule would receive the same ratings under the revised schedule. For Veterans who receive a 30 percent rating under the current schedule, Compensation Service estimates 90 percent would receive a zero percent rating, and the remaining 10 percent would receive a 10 percent rating under the revised schedule. Similarly, for Veterans who receive a 50 percent rating under the current schedule, Compensation Service estimates 90 percent would receive a zero percent rating, five percent would receive a 10 percent rating, and five percent would receive a 50 percent rating under the revised schedule.

In 2020, 39,460 Veterans were granted a service-connected rating for sleep apnea. Based on the 2020 distribution of sleep apnea accessions to the compensation rolls, 2,303 of these Veterans were rated at 30 percent, and 35,901 were rated at 50 percent disabled.[1] If rated under the revised criteria, 36,409 would have received a different rating under the revised criteria.

To estimate the caseload for 2022–2031, sleep apnea accessions were projected as a percentage of the total Veteran accessions from the 2022 President's Budget; the estimated number of new baseline sleep apnea ratings is 56,618 in 2022. The historical rating distribution for sleep apnea was then applied to the estimated sleep apnea accessions by degree of disability for 2022–2031. The number of Veterans who would receive a different rating for sleep apnea each year (approximately 52,000 annually) was calculated based on the assumptions provided by Compensation Service (i.e. 100 percent of Veterans accessing the compensation rolls at 30 percent and 95 percent of

[1] The number of Veterans service-connected for sleep apnea is growing rapidly, as demonstrated by a 88 percent increase between 2015 (193,429 Veterans) and 2020 (363,687 Veterans).

Veterans accessing the compensation rolls at 50 percent for sleep apnea each year under the current rating criteria). Veteran compensation termination rates from the 2022 President's Budget were utilized to calculate the cumulative running caseload total in the out-years.

Savings were estimated by comparing projected costs for sleep apnea accessions from 2022–2031 based on the rating distributions under both the current and revised rating criteria. For purposes of this cost estimate, VA assumes 80 percent of Veterans granted service connection for sleep apnea are on the compensation rolls for multiple conditions, while the other 20 percent will access the rolls with only the sleep apnea rating. For the 20 percent of Veterans accessing the rolls with only the sleep apnea rating, the combined rating is equal to the sleep apnea rating. Average costs by degree of disability from the 2022 President's Budget were applied under both the current and revised rating schedules. Savings were calculated by taking the difference in cumulative costs under the current and revised rating schedules. The resulting budgetary impact was a savings of $110 million in 2022 (10,963 Veterans x $839.90 average monthly savings x 12 months).

For the 80 percent of Veterans who are on the rolls for multiple service-connected disabilities, VA assumes the combined degree of disability for the other conditions is 50 percent, based on the current average combined degree of disability for Veterans receiving compensation. For these Veterans, the combined rating with sleep apnea was estimated by applying the sleep apnea rating to the current combined 50 percent rating for other conditions. Average costs by degree of disability from the 2022 President's Budget were applied to the combined degree of disability rating distribution under both the current and revised rating schedules. Savings were calculated by taking the difference in cumulative costs under the current and revised rating schedules.

Table 3:

DC 6847		
FY	**Caseload**	**Transfer Savings ($000)**
2022	52,241	($708,127)
2023	103,049	($1,454,028)
2024	151,708	($2,190,813)
2025	197,961	($2,925,756)
2026	241,856	($3,658,034)
5-Year Total		**($10,936,757)**
2027	284,482	($4,403,249)
2028	325,863	($5,161,513)
2029	366,031	($5,933,088)
2030	405,014	($6,718,168)
2031	442,843	($7,517,005)
10-Year Total		**($40,669,781)**

2. *DC 6100 – Hearing loss*
   DC 6260 – Tinnitus

VA proposes to delete DC 6260, tinnitus, and discontinue standalone evaluations for tinnitus. This is because current medicine reflects that tinnitus likely results from abnormal neural activity at some point or points in the auditory pathway, which is incorrectly interpreted by the brain as an actual sound. As a result, it is a symptom associated with an underlying condition, such as hearing loss, Meniere's disease, traumatic brain injury and cerebral atherosclerosis, not an independent disease. Instead, VA proposes to evaluate tinnitus as a part of the underlying pathology (i.e., Meniere's disease, hearing loss, traumatic brain injury). Accordingly, VA proposes to add a 10 percent evaluation level to DC 6100, Hearing Loss, which will be assigned when tinnitus is diagnosed as part of or secondary to service-connected hearing loss and the hearing loss is rated at 0 percent.

This change would only apply to new claimants or those seeking an increased evaluation of already-service-connected tinnitus.

Data provided by VA's Office of Performance, Analysis, and Integrity (PA&I) indicated that in 2020, 198,573 Veterans were newly rated for tinnitus under DC 6260.[2] Of those Veterans, 56,695 were also service connected at the 0 percent level for hearing loss (DC 6100). Under this regulation, these Veterans would still receive a 10 percent rating under DC 6100 and would not be impacted by this change. The other 141,878 Veterans were either service-connected traumatic brain injury (5,555), service connected for Meniere's disease (100), service connected for hearing loss at a compensable level (16,341), or not service connected for any other underlying pathology (121,161). Under the revised rating schedule, these Veterans would not have received a standalone evaluation for their tinnitus condition and are the basis for the projected future caseload that would result in savings under this regulation.

The annual Veteran caseload was projected out to 2031 as a percentage of total accessions based on the 2022 President's Budget. Based on these projections, the estimated number of new baseline tinnitus ratings is estimated to reach 284,920 in 2022, and the estimated number without service-connected hearing loss is approximately 200,000 per year. Cumulative caseload was estimated by adding annual caseload in each year and applying termination rates from the 2022 President's Budget. Compensation Service estimated 20 percent of these Veterans (40,714 in 2022) would be on the rolls for only tinnitus and therefore no longer access the rolls under this regulation. Savings for these Veterans were calculated by applying the average payment rate at the 10 percent disability level ($148.53 per month in 2022), based on the 2022 President's Budget. The resulting budget impact is approximately $73 million ($148.53 x 12 x 40,714) in 2022 and $146million in 2023, with roughly linear increases thereafter.

Compensation Service further estimated 80 percent of the affected Veterans (162,858 in 2022) are on the disability compensation rolls for other conditions not associated with tinnitus. These Veterans would no longer be eligible for an additional 10 percent rating associated with tinnitus. This caseload was distributed by combined disability based on the distribution of all Veterans on the compensation rolls as of September 2020. The

[2] Tinnitus is by far the most prevalent service-connected disability among Veterans, with nearly two million Veterans service-connected for tinnitus in 2020.

impact of not adding a 10 percent rating to the overall combined disability was calculated and utilized to estimate total savings at each combined rating level. Average payments at each combined degree of disability are based on the 2022 President's Budget. Note that at some rating levels, an additional 10 percent rating may not affect the overall combined degree of disability. Veterans whose combined degree of disability did not change are excluded from the table below, which shows results for 2022, and from the estimates of roughly linear increases in budget impacts in subsequent years.

Table 4:

DC 6100 & DC 6260 in 2022			
Rating Difference (Old Criteria vs. New Criteria)	**Estimated Number of Affected Veterans**	**Estimated Difference in Monthly Payment**	**Transfer Savings ($000)**
10% vs. 0%	40,972	($148)	($72,708)
20% vs. 10%	28,759	($147)	($50,896)
30% vs. 20%	13,629	($203)	($33,253)
40% vs. 30%	12,295	($223)	($32,895)
50% vs. 40%	12,138	($299)	($43,478)
60% vs. 50%	9,652	($369)	($42,787)
Total	**117,445**		**($276,017)**

Table 5:

DC 6100 & DC 6260		
Fiscal Year	**Caseload**	**Transfer Savings ($000)**
2022	117,445	($276,017)
2023	231,668	($555,907)
2024	341,064	($836,435)
2025	445,045	($1,115,480)
2026	543,728	($1,394,203)
5-Year Total		**($4,178,042)**
2027	639,556	($1,677,683)
2028	732,589	($1,965,974)
2029	822,893	($2,259,159)
2030	910,533	($2,557,320)
2031	995,579	($2,860,554)
10-Year Total		**($15,498,733)**

3. DC 6602 – Asthma, bronchial

Currently, evaluations under DC 6602 are assigned at the 0, 10, 20, 30, 60, or 100 percent levels. This regulation does not change these evaluation levels; however, the requirements to receive a 100 percent rating will be lessened. Compensation Service assumes half of the future accessions rated at the 60 percent level under the current criteria will instead receive a 100 percent rating under the revised criteria. Data provided by PA&I indicates that in 2020, 340 Veterans were assigned a 60 percent rating under DC 6602. This caseload was projected out to 2031 as a percentage of total Veteran compensation accessions based on the 2022 President's Budget. Additionally, in August 2021, VA issued a rule amending its adjudication regulations to establish presumptive service connections for three chronic respiratory health conditions, i.e., asthma, sinusitis, and rhinitis, in association with presumed exposures to fine, particulate matter. As a result, VA estimates an additional 3,559 accessions under DC 6602 in 2022 and 7,753 additional accession from 2022 - 2031. Based on these assumptions, an estimated 4,048 Veterans will receive a new 60 percent rating under DC 6602 in 2022, and under the revised criteria, half of these Veterans, or 2,024, would have received a 100 percent rating. The resulting number of new baseline asthma ratings at the 100 percent level rather than the 60 percent level is 2,024 in 2022, 872 in 2023, and total 6,231 from 2022 - 2031.

Compensation Service further assumes that 10 percent of Veterans on the rolls at the 60 percent level under DC 6602 would re-open their claims for increased evaluation in each of the first three years (2022 – 2024). Based on the data from PA&I, in 2020 there were 8,962 Veterans rated at the 60 percent level on the rolls under this DC. Compensation Service estimates that half, or 4,481 Veterans, would be eligible for an increase to a 100 percent rating under the revised criteria. The caseload eligible for an increase was projected out to 2022 - 2024 based on total Veteran compensation caseload from the 2022 President's Budget, and a 10 percent application rate was applied. The resulting number of increased Asthma ratings at the 100 percent level rather than the 60 percent level averages 509 annually from 2022 – 2024. Cumulative caseload was estimated by adding the accessions and reopened claims eligible for a 60 percent rating under the current criteria and a 100 percent rating under the proposed criteria and applying termination rates from the 2022 President's Budget.

Costs were calculated by applying the difference between average disability compensation payment rates at the 60 and 100 percent levels to the estimated cumulative caseload in each respective year. Projected average payments rates in the out-years are based on the 2022 President's Budget.

Table 6:

DC 6602			
Veteran Rating Changes in FY 2022			
Rating Difference (Old Criteria vs. New Criteria)	**Estimated Number of Affected Veterans**	**Estimated Difference in Monthly Payment**	**Transfers ($000)**
60% vs 100%	2,514	$2,204	$66,498

DC 6602		
Fiscal Year	**Caseload**	**Transfers ($000)**
2022	2,514	$66,498
2023	3,827	$103,354
2024	4,810	$132,759
2025	5,074	$143,127
2026	5,326	$153,691
5-Year Total		**$599,429**
2027	5,572	$164,488
2028	5,810	$175,458
2029	6,040	$186,599
2030	6,263	$197,939
2031	6,479	$209,475
10-Year Total		**$1,533,388**

<u>DCs with Minor Budgetary Impact</u>

1. DC 6204 – Peripheral vestibular disorders

Currently, Veterans are assigned a disability under DC 6204 at the 0, 10, or 30 percent levels. VA proposes to add a 100 percent disability level. Compensation Service assumes one percent of future accessions rated at the 30 percent level under the current criteria will receive a 100 percent rating under the revised criteria. Additionally, Compensation Service assumes one percent of current caseload rated at the 30 percent level would qualify at the 100 percent level under the new criteria, and 10 percent of Veterans on the rolls at the 30 percent level would re-open their claims for increased evaluation in each of the first three years. Estimated costs are $1.4 million in the first year, $19.7 million for five years and $65.8 million over ten years.

2. DC 6221 / DC 6504 – Nose, loss of part of, or scars

Currently, this condition is rated under DC 6504. VA proposes to relocate this condition to DC 6221 and revise the rating criteria. Currently, Veterans are assigned a disability

under DC 6504 at the 0, 10, or 30 percent levels. VA proposes to add a 20 percent disability level under DC 6221 and clarify rating criteria at the other levels. Compensation Service assumes 30 percent of future accessions rated at the 10 percent level under the current criteria will receive a 20 percent rating under the revised criteria. Additionally, 10 percent of Veterans on the rolls at the 10 percent level would re-open their claims for increased evaluation in each of the first three years. Estimated costs are $11,000 in the first year, $146,000 for five years, and $394,000 over ten years.

3. DC 6231 / DC 6520 – Larynx, stenosis of

Currently, this condition is rated under DC 6520. VA proposes to relocate this condition to DC 6231 and revise the rating criteria. Currently, Veterans are assigned a disability under DC 6504 at the 0, 10, 30, 60, or 100 percent levels. VA proposes to revise the disability rating levels to 0, 30, 50, 70, or 100 percent. Compensation Service assumes future accessions rated at the 10 percent level under the current criteria will receive a 30 percent rating under the revised criteria and that Veterans rated at the 60 percent level under the current criteria would be evenly split between the 50 and 70 percent levels under the revised criteria. Veterans rated at 0, 30, and 100 percent under the current criteria would receive the same rating under both the current and proposed criteria. Additionally, 10 percent of Veterans on the rolls at the 10 or 60 percent levels would re-open their claims for increased evaluation in each of the first three years. Estimated costs are $27,000 in the first year, $365,000 for five years, and $1.0 million over ten years.

4. DC 6239 – Disease of the salivary glands and/or associated ducts, other than neoplasm

VA proposes to add new DC 6239 for diseases of the salivary glands, other than neoplasms. Disability ratings under DC 6239 will be at the 0, 10, and 20 percent levels. Compensation Service estimates a 0.1 percent prevalence rate, 0.005 percent incidence rate, and a 30 percent application rate (spread evenly over the first three years for Veterans who currently have the condition). Compensation Service further assumes that accessions will be split evenly between the 10 and 20 percent levels. Estimated costs are $5.8 million in the first year, $70.8 million for five years, and $173.2 million over ten years.

General Rating Formula (GRF) for Conditions of the Respiratory System

VA proposes adding a GRF to the beginning of the respiratory system. The proposed formula incorporates much of the criteria currently used by several DCs for respiratory conditions. The GRF will assign ratings at the 0, 10, 20, 30, 60, or 100 percent levels. No significant changes will occur to the rating criteria at the 0, 10, 20, or 30 percent levels. However, for several individual DCs, the requirements to receive a 100 percent rating under the proposed GRF were lessened compared to the current rating criteria. In addition, some DCs rated under the new GRF include a provision to add 10 percent to any rating level if certain medications are prescribed.

Under the proposed GRF, Compensation Service assumes half of future accessions rated at the 60 percent level under the current criteria will instead receive a 100 percent rating. Additionally, 10 percent of Veterans on the rolls at the 60 percent level would re-open their claims for an increased evaluation in each of the first three years.

For DCs that include the additional provision to add 10 percent to the rating level based on prescribed medications, Compensation Service assumes half of Veterans under each DC would be prescribed those medications.

Costs associated with the new GRF are listed under individual DCs below:

5. *DC 6600 – Bronchitis, chronic*
   DC 6600 will utilize the new GRF for the respiratory system. Estimated costs are $1.3 million in the first year, $17.2 million for five years, and $48.9 million over ten years.

6. *DC 6601 – Bronchiectasis*
   DC 6601 will utilize the new GRF for the respiratory system. Estimated costs are $344,000 in the first year, $4.5 million for five years, and $12.6 million over ten years.

7. *DC 6603 – Emphysema, pulmonary*
   DC 6603 will utilize the new GRF for the respiratory system. Estimated costs are $635,000 in the first year, $8.6 million for five years, and $24.9 million over ten years.

8. *DC 6604 – Chronic obstructive pulmonary disease*
   DC 6604 will utilize the new GRF for the respiratory system. Estimated costs are $4.1 million in the first year, $56.4 million for five years, and $170.0 million over ten years.

9. *DC 6825 – Diffuse interstitial fibrosis*
   DC 6825 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $1.1 million in the first year, $16.0 million for five years, and $54.2 million over ten years.

10. *DC 6826 – Desquamative interstitial pneumonitis*
    DC 6826 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $2,000 in the first year, $28,000 for five years, and $111,000 over ten years.

11. *DC 6827 – Pulmonary alveolar proteinosis*
    DC 6827 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $4,000 in the first year, $71,000 for five years, and $280,000 over ten years.

12. *DC 6828 – Eosinophilic granuloma of lung*
    DC 6828 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $33,000 in the first year, $432,000 for five years, and $1.1 million over ten years.

13. *DC 6829 – Drug-induced pulmonary pneumonitis and fibrosis*
    DC 6829 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $58,000 in the first year, $831,000 for five years, and $2.7 million over ten years.

14. *DC 6830– Radiation-induced pulmonary pneumonitis and fibrosis*
    DC 6830 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $38,000 in the first year, $483,000 for five years, and $1.2 million over ten years.

15. *DC 6831 – Hypersensitivity pneumonitis*
    DC 6831 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $30,000 in the first year, $471,000 for five years, and $1.8 million over ten years.

16. *DC 6832– Pneumoconiosis*
    DC 6832 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $108,000 in the first year, $1.6 million for five years, and $5.3 million over ten years.

17. *DC 6833 – Asbestosis*
    DC 6833 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $4.5 million in the first year, $60.7 million for five years, and $179.0 million over five years.

18. *DC 6840 – Diaphragm paralysis or paresis*
    DC 6640 will utilize the new GRF for the respiratory system. Estimated costs are $185,000 in the first year, $2.7 million for five years, and $8.4 million over ten years.

19. *DC 6841 – Respiratory insufficiency due to spinal cord injury*
    DC 6641 will utilize the new GRF for the respiratory system. Estimated costs are $26,000 in the first year, $420,000 for five years, and $1.7 million over ten years.

20. *DC 6842 – Pulmonary disease secondary to kyphoscoliosis, pectus excavatum, or pectus carinatum*
    DC 6642 will utilize the new GRF for the respiratory system. Estimated costs are $53,000 in the first year, $755,000 for five years, and $2.5 million over ten years.

21. *DC 6843 – Traumatic chest wall defect, pneumothorax, hernia, etc.*
    DC 6643 will utilize the new GRF for the respiratory system. Estimated costs are $265,000 in the first year, $3.3 million for five years, and $7.7 million over ten years.

22. *DC 6844 – Post-surgical residual*

DC 6644 will utilize the new GRF for the respiratory system. Estimated costs are $476,000 in the first year, $6.0 million for five years, and $14.4 million over ten years.

23. *DC 6845 – Chronic pleural effusion or fibrosis*
DC 6645 will utilize the new GRF for the respiratory system. Estimated costs are $423,000 in the first year, $5.8 million for five years, and $17.3 million over ten years.

24. *DC 6846 – Sarcoidosis*
DC 6846 will utilize the new GRF for the respiratory system. Under this DC, Veterans prescribed certain medications are eligible for a 10 percent increase to their evaluation. Estimated costs are $899,000 in the first year, $12.1 million for five years, and $33.7 million over ten years.

25. *DC 6848 – Lung Transplantation*
VA proposes to add new DC 6848 for lung transplantation. Under this DC, VA will assign a 100 percent evaluation for one year following discharge from the hospital for such surgery. After one year, Veterans will be rated based on residuals, with a minimum 30 percent evaluation. Currently, Veterans who undergo lung transplantation are rated under an analogous code and receive a temporary 100 percent rating for six months following discharge from the hospital. After six months, the Veterans are assigned a rating based on residuals. Compensation Service assumes that the ratings based on residuals will not change under this new DC. Costs for adding this code represent six additional months of temporary 100 percent ratings for Veterans that undergo lung transplantation. Estimated costs are $3.9 million in the first year, $20.6 million for five years, and $43.6 million over ten years.

Table 7:

Total: DCs with Minor Cost Impact		
Fiscal Year	**Caseload**	**Transfers ($000)**
2022	3,337	$25,620
2023	6,357	$47,927
2024	9,265	$70,679
2025	9,725	$78,748
2026	10,161	$86,934
5-Year Total		**$309,908**
2027	10,579	$95,273
2028	10,978	$103,684
2029	11,360	$112,251
2030	11,726	$120,932
2031	12,075	$129,733
10-Year Total		**$871,782**

Contract Exams

VA estimates that this regulation would result in an additional 4,215 Veteran disability claims in 2022, and 24,523 Veteran disability claims over ten years. All of these claims are expected to require disability exams in 2022, and 18,255 claims are expected to require disability exams over ten years. These estimates are based on the assumptions previously described for Veterans on the rolls along with an assumed 80/20 split for grants and denials, a 33 percent reopened claim rate, a 30 percent initial appeal rate under the Appeals Modernization Act framework, and a 20 percent refiled appeal rate. Based on historical data, VBA estimates approximately 1.4 exams will be requested per disability claim from 2022–2031. Assuming 1.4 exams per claim results in 5,854 exams in 2022 and 25,354 exams over ten years.

VBA assumes all exams will be funded through VBA contracts. These contracts are reimbursed from the mandatory C&P account. Based on the 2022 President's Budget, the average cost per exam is expected to be $1,380 in 2022 and increase to $1,815 by 2031. Total obligations for contract exams were calculated by applying the average cost per contract exam to the projected exams.

VBA General Operating Expenses (GOE) Costs

The GOE estimate for fiscal year (FY) 2022 is $3.5 million and includes salary, benefits, rent, travel, supplies, other services, and equipment. Five-year costs are estimated at $15.8 million, and 10-year costs are estimated at $19.1 million.

Table 8:

GOE Costs		
FY	**FTE**	**Obligations ($000)**
2022	25	$3,483
2023	33	$4,651
2024	34	$4,868
2025	13	$1,899
2026	6	$872
5-Year Total	**34**	**$15,773**
2027	5	$634
2028	5	$652
2029	5	$669
2030	5	$687
2031	5	$708
10-Year Total	**5**	**$19,123**

Methodology: GOE costs for FY 2022 were developed using 25 full-time equivalents (FTE) to include two GS-13 Supervisors, one GS-13 Quality Reviewer, nine GS-12 Rating Veterans Service Representatives, 11 GS-10 Veterans Service Representatives, and two GS-6 Claims Assistants. In addition to the GS-levels above, all FTE costs were developed using the average VBA locality pay.

Standard rates were applied for benefits, rent, travel, supplies, and equipment. Rent costs were based on an estimated 75% capacity. Additionally, travel costs were based on an average of one week of management travel and determined using a standard travel rate. Travel increases to two weeks of management travel in the outyears.

VHA Transfers

Enrollment Impact

A simulation of the impact of revised rating criteria was run on historical disability and enrollment data. The distribution of VHA enrollment by priority resulting from the simulation was compared to the actual historical distribution, in order to model the impact of the revised rating criteria. Zero impact is assumed on new enrollment because the vast majority of the rating changes would only impact Veterans that are already enrolled, or would still otherwise enroll, in VA health care. The changes in rating levels are not expected to materially change Veterans' desire to enroll in VHA; the changes are not expected to cause an otherwise ineligible Veteran to become newly eligible to enroll.

The ENT rating changes are projected to reduce the number of service-connected ratings on average. Table 9 summarizes these results by priority level.

Expenditure Impact

The expenditure impact is assumed to come from changes in reliance on VHA for medical care as higher or lower enrollment priorities are attained. The underlying morbidity and health care needs of Veterans are not expected to change when the rating level definitions change, but by attaining a different priority level it is assumed that the Veteran's reliance on VHA for health care services will shift up or down. Using this high-level approach, the impact was estimated to be a $60 million reduction in the first year of implementation (FY 2022), with gradually increasing reductions up to $290 million in year five (FY 2026) and $650 million in year ten (FY 2031). The table below summarizes these results. These results are also summarized in Table 9.

Table 9:

Fiscal Year[3]	Expenditure Impact (millions)[4]	Net Enrollment Change by Priority[5]				
		P1a	P1b	P2	P3	Non-SCD
2022	($60)	(11,585)	(1,549)	1,905	(7,303)	18,532
2023	($120)	(21,672)	(2,435)	3,469	(15,325)	35,963
2024	($180)	(30,434)	(2,841)	4,194	(24,977)	54,058
2025	($230)	(38,459)	(2,976)	4,404	(36,457)	73,488
2026	($290)	(46,324)	(3,229)	4,232	(50,882)	96,203
5-Year Total	**($880)**					
2027	($360)	(54,189)	(3,482)	4,060	(65,307)	118,918
2028	($420)	(62,054)	(3,735)	3,888	(79,732)	141,633
2029	($490)	(69,919)	(3,988)	3,716	(94,157)	164,348
2030	($570)	(77,784)	(4,241)	3,544	(108,582)	187,063
2031	($650)	(85,649)	(4,494)	3,372	(123,007)	209,778
10-Year Total	**($3,370)**					

Methodology and Discussion

Enrollment Impact

This analysis relies on service-connected disability adjudication estimates provided by the Veterans Benefits Administration (VBA). VBA provided assumptions regarding how disability ratings under the old rating criteria would compare to ratings under the new criteria (e.g. “For Veterans who receive a 30 percent [sleep apnea] rating under the current schedule, Compensation Service estimates 90 percent would receive a zero percent rating, and the remaining 10 percent would receive a 10 percent rating under the revised schedule.”). VBA also provided assumptions regarding what percentage of Veterans would request reevaluations for conditions that generally receive higher ratings under the new criteria.

Disability-level data from VBA representing the FY2015 – FY2019 period was used to simulate the new rating conditions over a five-year period and model what FY2019 enrollment by priority may have looked like if these changes were put in place in FY2015. The simulation was run on all enrolled Veterans that are present in the VBA data. This excludes Veterans that did not have any service-connected disabilities

[3] Simulation was run on fiscal years 2015 - 2019, and then the changes in Veteran counts by Priority were used as proxies to estimate expenditure impacts from fiscal years 2022 - 2026. Projections for fiscal years 2027 - 2031 were extrapolated based on the simulation trends.

[4] Estimated based on changes in reliance on VHA for medical care as higher or lower enrollment priorities are attained.

[5] P1a = 70% to 100% overall service-connected disability rating level
P1b = 50% or 60% overall service-connected disability rating level
P2 = 30% or 40% overall service-connected disability rating level
P3 = 10% or 20% overall service-connected disability rating level
Non-SCD = 0% overall service-connected disability rating level

(generally priorities 4 – 8) at the time. For each fiscal year, the simulation processed all service-connected disabilities for a given Veteran through the revised rating rules. For conditions not impacted by the rating changes, no changes were made to the original rating level. For sleep apnea, asthma, and tinnitus conditions, the following hierarchy was applied.

1. For new tinnitus conditions (i.e. the Veteran did not have the condition in the prior fiscal year), the rating was set to 0%. If the Veteran had a hearing loss condition that was rated at 0%, the hearing loss rating was set to 10%.

2. A portion of Veterans with asthma conditions were flagged as Veterans that would request rating reevaluations, consistent with the assumptions from VBA. For asthma conditions that were not new (i.e. the Veteran had the condition in the prior fiscal year) and where the Veteran was flagged as requesting a reevaluation, a rating level was assigned that simulated the new rating criteria but did not allow a downgrade in rating level (i.e. the reevaluation outcome was floored at the original rating). This approach is consistent with the proposed rule change.

3. For new sleep apnea and asthma conditions (i.e. the Veteran did not have the condition in the prior fiscal year), a rating level was assigned that simulated the new rating criteria. The simulation was calibrated such that the results would be consistent with the VBA assumptions documented above. For example, out of all Veterans who, under the current rules in the last five years, received a 30% rating for a new sleep apnea condition, approximately 90% of those cases result in the Veteran receiving a 0% rating under the proposed rule.

4. For asthma and sleep apnea conditions that were not new (i.e. the Veteran had the condition in the prior fiscal year) and where the Veteran was not flagged for reevaluation, no change was made to the raw rating level. This is consistent with the proposed rule.

After running all disabilities for a fiscal year through the simulation, the resulting composite service-connected disability ratings were calculated for each Veteran.

The first five years of the projections (fiscal years 2022 to 2026) were based directly on the simulation results. The year six to ten projections (fiscal years 2027 to 2031) were extrapolated based on the simulation trends.

<u>Expenditure Impact</u>

The process to obtain impact estimates for non-Long-Term Services and Supports (LTSS) Long Stay services is described below:

1. Started with the average per member per year (PMPY) medical expenses for non-LTSS Long Stay services from BY19 Scenario BAA9.

2. The BY19 reliance for non-LTSS Long Stay services and age band was used to gross up the PMPY costs to a level representing full reliance on VHA.

3. The estimated full reliance PMPY cost for non-LTSS Long Stay services was assumed to remain unchanged as enrollees transition to a different priority; only the level of reliance on VHA is assumed to change as their priority changes.

4. The expenditure impact for enrollees due to the change in reliance was estimated by applying the before-and-after priority reliance to the full-reliance PMPY for non-LTSS Long Stay services, then taking the difference. We assumed only one half of the change in reliance is realized for this population.

The process to arrive at impact estimates for LTSS Long Stay services differs from the more general process above because eligibility for these long-stay services is largely reserved for P1a enrollees. The process to calculate the impact estimates for LTSS Long Stay services is described below:

1. The average PMPY medical expenses for LTSS Long Stay services were calculated by 5-year age-band and enrollment priority.

2. The expenditure impact for LTSS Long Stay was calculated as the adjusted PMPY of the transition priority, less the adjusted PMPY of the starting priority.

Accounting Statement and Table:

Five Year Projection in Real Dollars (Annualized 3% & 7% Values, no inflation rates applied)										
Category	***Transfers($000)***									
Year Dollars		FY2022	FY2023	FY2024	FY2025	FY2026	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*						$0	$0	$0	$0
	Pri. Est.	**$943,944**	**$1,969,793**	**$2,994,510**	**$4,047,274**	**$5,099,967**	**$13,508,797**	**$11,770,948**	**$2,863,794**	**$2,683,014**
	High Est.						$0	$0	$0	$0
Category	***Costs ($000)***									
Year Dollars		FY2027	FY2028	FY2029	FY2030	FY2031	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*						$0	$0	$0	$0
	Pri. Est.	**$3,483**	**$4,651**	**$4,868**	**$1,899**	**$872**	$14,660	$13,362	**$3,108**	**$3,046**
	High Est.						$0	$0	$0	$0
Ten Year Projection in Real Dollars (Annualized 3% & 7% Values, no inflation rates applied)										
Category	***Transfers($000)***									
Year Dollars		FY2027	FY2028	FY2029	FY2030	FY2031	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*						$0	$0	$0	$0
	Pri. Est.	**$6,179,657**	**$7,266,854**	**$8,381,894**	**$9,525,087**	**$10,686,787**	**$46,461,684**	**$35,906,122**	**$6,825,602**	**$6,344,058**
	High Est.						$0	$0	$0	$0
From/To: & Period Covered:	*From:*	Federal Government			*To:*	Eligible Veterans			*Period Covered:*	FY2022-FY2031
Notes:										
Category	***Costs ($000)***									
Year Dollars		FY2027	FY2028	FY2029	FY2030	FY2031	Present Value		Annualized	
							3%	7%	3%	7%
Federal Annualized Monetized	*Low Est.*	*na*	*na*	*na*	*na*	*na*	$0	$11,770,948	$0	$1,566,279
	Pri. Est.	**$634**	**$652**	**$669**	**$687**	**$708**	$17,302	$11,781,866	$3,638	$1,569,509
	High Est.	*na*	*na*	*na*	*na*	*na*	$0	$11,780,475	$0	$1,567,546
From/To: & Period Covered:	*From:*	Federal Government			*To:*	Eligible Veterans			*Period Covered:*	FY2022-FY2031
Notes:										
Category	***Benefits***									
Notes:										

Submitted by: Veterans Benefits Administration (VBA)
Questions regarding the regulatory impact analysis should be submitted to 211-regulations.vbavaco@va.gov.

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